MDR Tracking Number: M5-04-1872-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on February 25, 2004.

The IRO reviewed stimulation, massage, ultrasound, and therapeutic procedures rendered from 12-10-03 to 12-22-03 they were denied based upon "U".

The IRO concluded that the stimulation, massage, ultrasound, and therapeutic procedures from 12-10-03 through 12-22-03 was medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 26, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-19-03	97150	$23.61	0	Y,N,H	$27.00	Medicare Fee Guideline effective 08-01-03	Review of the Daily Patient's Record submitted by the requestor does not support billing of therapeutic procedures in a group of 2 or more individuals; therefore, reimbursement is not allowed.
12-22-03	97150	$23.61	0	Y,N,H	$27.00	Medicare	Review of the Daily Patient's Record

						Fee Guideline effective 08-01-03	submitted by the requestor does not support billing of therapeutic procedures in a group of 2 or more individuals; therefore, reimbursement is not allowed.
TOTAL		$47.22					The requestor is entitled to reimbursement of $**0.00**

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-10-03 through 12-22-03 in this dispute.

This Decision & Order is hereby issued this 18th day of August 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

May 25, 2004

Re: IRO Case # M5-04-1872, amended 5/26/04
IRO Certificate #4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___

received relevant medical records, any documents obtained from parties in making the adverse

determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is board Certified in Neurological Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of Disputed Services 11/19/03 – 11/24/03
2. Explanation of benefits
3. Request for Reconsideration 1/19/04
4. RME report 10/29/03
5. MRI lumbar spine report 3/11/03, 1/7/04
6. Operative Report 8/6/03
7. Surgeon consultation report 3/27/03
8. Clinic notes 2/11/03 forward
9. Surgeon notes
10. TWCC 69, Report of Medical Evaluation 1/29/04
11. Another surgeon's notes and report 2004
12. Physical therapy treatment records

History

The patient is a 46-year-old male who on ___ was lifting some scaffolding and developed back pain. The back pain persisted, but he continued to work. The back pain became so severe that on 2/11/03 he sought medical help. The patient had both right and left lower extremity pain at times, in addition to his back pain. He had a history of lumbar disk surgery at the L4-5 level several years before. A 3/11/03 MRI showed a right sided T11-12 disk herniation with spinal cord compromise. After the MRI, consultations, additional opinions, and insurance denials delayed an indicated procedure, which was finally performed on 8/6/03, consisting of thoracic laminectomy with disk rupture removal at the T11-12 space. The patient did poorly post operatively, with continued discomfort limits in range of motion, and general problems that could benefit from a physical therapy program.

Requested Service(s)

Stimulation, massage, ultrasound, therapeutic procedures 12/10/03 and 12/22/03

Decision
I disagree with the carrier's decision to deny the requested services.

Rationale
The patient's surgeon did recommend continued stretching exercises, and while there was no mention of stimulation, massage or ultrasound, these services enhanced the potential help of an exercise program. A subsequent MRI on 1/7/04 showed potential problems in the surgical area, but because the patient's neurologic examination was normal, the surgeon could have appropriately determined that a physical therapy program was indicated before performing reevaluation by way of MRI. Therefore, the MRI was not thought necessary before an attempt was made to relieve the patient's problems with the physical therapy measures that were introduced.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.